LA LUNA CENTER

Dear Medical Professional,

This patient is seeking care to address disordered eating behaviors. In order to admit to one of our treatment programs, the following forms, physical assessments and testing need to be completed within 28 days of admission. Additionally patients must be able to administer their own medication and deemed medically stable for outpatient care. Upon completion**, please fax all required documentation to 303-200-7098 for both Boulder and Fort Collins treatment center locations.**

The following information is required to ensure safe and appropriate placement of this patient:

1. Laboratory testing results (must be completed within the 28 days prior to admission):

• CMP (Complete Metabolic Panel) • CBC with differential • Urine Drug Screen 7 or 10 Panel • EKG • Amylase • Urine pregnancy test, qualitative (as applicable)	• TSH* • Urinalysis* • Nuclear Medicine Bone Density Scan (i.e. DEXA / DXA)* • Vitamin D*

*These laboratory reports are not required for patients who are stepping down from Residential or Partial Hospitalization or from other eating disorder treatment centers.

2. EKG (must be completed within the 28 days prior to admission)

   *Note: If EKG is abnormal and follow-up care is not recommended by the provider completing the medical clearance, the provider must complete attestation (Page 6 of this packet) indicating that no follow-up care is recommended at this time.

3. Updated medication list including all over-the-counter medications, supplements and medications not prescribed by this office
4. Medical History and Physical Exam (forms provided)
5. Most recent Progress Note (if applicable)
6. Signed affirmation by the patient's provider stating that the patient is medically stable to participate in outpatient treatment at a level of care recommended by the La Luna Center treatment team

Please call our office with any questions or concerns and thank you for your cooperation and support!

Boulder 720-470-0010; Fort Collins 970-282-8282

Download a copy of this form at http://lalunacenter.com/forms

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Current Vital Signs and Physical Information:

Sex		**Gender Identity**	
Height		**Weight**	
Temperature		**Respirations**	
Blood Pressure (sitting)		**Pulse (sitting)**	
Blood Pressure (standing)		**Pulse (standing)**	

Medications – Please include over-the-counter medications, supplements and any known medications prescribed by other providers *(a printed list of medications with letter head or identifying marker from your office is acceptable)***:**

Name	Dose	Route	Frequency	Indication	Other Instructions

Allergies

Name	Reaction	Name	Reaction

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Medical History

Primary Diagnosis *(check the box for the diagnosis which most closely describes the patient's behaviors)*:

- ☐ **Anorexia Nervosa:** Restriction of intake leading to low body weight, fear of gaining weight/being overweight, distorted view of one's body. Subtypes: Restricting – restricts intake, Binge/Purge – some episodes of binge eating and/or purging
- ☐ **Binge Eating Disorder:** Recurring episodes of overeating coupled with marked feelings of lack of control/ability to stop.
- ☐ **Avoidant/Restrictive Food Intake Disorder:** Intake is limited based on texture, taste, smell, appearance or past negative experience with food.
- ☐ **Bulimia Nervosa:** Excessive consumption of food in a short period of time, repeated episodes of purging via self-induced vomiting, laxative abuse etc., concern with body weight and shape.
- ☐ **Other Specified Feeding/Eating Disorder:** All criteria for Anorexia Nervosa, Bulimia Nervosa and Binge Eating Disorder without significant weight disturbance and with differing frequency of behaviors.

Other Physical or Mental Health Conditions:

_____

_____

Alcohol Use/Abuse and Illicit Drug/Prescription Drug Abuse (if yes, please describe below):

_____

_____

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Medical History	When	Stable/Unstable	Resolved
☐ Cardiovascular/Heart Disease			
☐ Respiratory Disorders			
☐ Blood Disorders			
☐ Cancer			
☐ Gastrointestinal Conditions			
☐ Genitourinary Conditions			
☐ Neurologic Disorders/Events			
☐ Head Trauma			
☐ Endocrine Disorders			
☐ Kidney Disease			
☐ Liver Disease			
☐ Osteoporosis			
☐ Surgery (please list)			

Patient Name_____Date of Birth_____

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Physical Exam

Review of Systems (please check all that apply)

Constitutional: ☐ Fever ☐ Fatigue ☐ Pain ☐ Significant weight change	Eyes: ☐ Watery/purulent ☐ Discharge ☐ Redness ☐ Blurred vision ☐ Double vision	ENT: ☐ Hearing loss ☐ Ringing ☐ Pain in ears ☐ Difficulty swallowing ☐ Dental problems/enamel erosion ☐ Drainage ☐ Mouth sores
Cardiovascular ☐ Chest Pain ☐ Palpitations ☐ SOB with exercise ☐ Presyncope/syncopal episodes ☐ Edema ☐ Hypertension ☐ Hypotension	Respiratory ☐ Cough ☐ SOB ☐ Wheezing ☐ Sputum ☐ Asthma	Gastrointestinal ☐ Appetite loss ☐ Constipation ☐ Diarrhea ☐ Nausea, Vomiting ☐ Abdominal pain ☐ Heartburn ☐ Bloating ☐ Hematemesis
Genitourinary ☐ Frequency ☐ Dysuria ☐ Incontinence ☐ Amenorrhea ☐ Irregular Menses ☐ Sexual dysfunction ☐ Hematuria ☐ Nocturia ☐ Infertility	Musculoskeletal ☐ Joint irregularities ☐ Physical weakness ☐ Muscle cramps ☐ Arthritis ☐ Decreased muscle mass	Skin/Breasts ☐ Rash ☐ Itching ☐ Dry skin ☐ Lanugo ☐ Varicose veins ☐ Breast pain ☐ Breast lumps/discharge
Neurological ☐ Headaches ☐ Lightheaded, dizzy ☐ Numbness, tingling ☐ Tremors ☐ Memory loss ☐ Confusion	Endocrine ☐ Hormone deficiency ☐ Thyroid dysfunction ☐ Diabetes Mellitus ☐ Heat/cold intolerance ☐ Excess thirst	Hematological/lymphatic ☐ Delay in healing ☐ Bleed or bruise easily ☐ Anemia ☐ Enlarged glands

Patient Name_____Date of Birth_____

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Physical Exam

	Normal	Abnormal	Description (if abnormal)
Skin	☐	☐	
HEENT	☐	☐	
Neck ● Thyroid ● Parotid Glands ● Lymph Nodes ● Veins/Carotids	☐	☐	
Chest	☐	☐	
Lungs	☐	☐	
Heart	☐	☐	
Abdomen	☐	☐	
Genital	☐	☐	
Extremities ● Joints ● Clubbing/Cyanosis ● Peripheral pulses	☐	☐	

Additional applicable information not otherwise specified:

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Medical Professional Attestation

Based on my physical examination, I certify that this patient is medically stable, able to administer their own medication, and appropriate to attend the recommended treatment program as determined by La Luna Center's team of mental healthcare professionals.

Provider Signature:	
Date:	

Follow Ups & Recommendations:

Follow - Up Office Visit:
Follow - Up Lab Work:
Exercise / Movement Restrictions (Please Check One): ☐ I defer to the recommendations of La Luna Center's eating disorder treatment team. ☐ Other:
Other:

If applicable:

I have reviewed the abnormal EKG for this patient and am not recommending follow-up care at this time. I understand that this patient will be entering an ambulatory facility within the next 28 days and confirm that the patient is medically stable and appropriate for these settings.

Provider Signature:	
Date:	